Pharmacy Prior Authorization

AETNA BETTER HEALTH ILLINOIS FAMILY HEALTH PLAN (MEDICAID)

Platelet Inhibitors (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois at **1-844-242-0908**.
When conditions are met, we will authorize the coverage of Platelet Inhibitors (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(please circle)*

Brilinta (ticagrelor) Zontivity (vorapaxar) prasugrel

Other, please specify_____

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis:_____ ICD Code:_____

Please circle the appropriate answer for each question.

1. Has this Aetna Better Health authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, then skip to question 6.]

2. Does the patient have high risk of bleeding or significant overt bleeding? Y N

   [If yes, then no further questions.]

3. Is this a request for Zontivity for a patient with peripheral artery disease (PAD) or a history of myocardial infarction (MI)? Y N

   [If yes, then no further questions.]

4. Was the patient originally started on medication after placement of a cardiac stent? Y N

   [If no, then no further questions.]

5. Does the patient have a history of stent restenosis? Y N

   If no, please provide rational for continued use:

   _____

   [No further questions.]

6. Was the patient stabilized in the hospital on the requested medication? Y N

   [If yes, then no further questions.]

7. Is this a request for Zontivity for a patient with peripheral artery disease (PAD) or a history of myocardial infarction (MI)? Y N

   [If no, then skip to question 10.]

8. Is the patient also taking aspirin or clopidogrel? Y N

   [If no, then no further questions.]

9. Does the patient have a history of stroke or transient ischemic attack (TIA), intracranial hemorrhage (ICH), or active pathological bleeding (e.g., peptic ulcer)? Y N

   [No further questions.]

10. Does the patient have a diagnosis of acute coronary syndrome (ACS) (e.g., unstable angina, STEMI, NSTEMI)? Y N

    [If no, then no further questions.]

11. Has the patient had an inadequate treatment response, intolerance, or contraindication to clopidogrel? Y N

    [If no, then no further questions.]

12. Is the patient taking up to 100 mg of aspirin daily? Y N

    [If no, then no further questions]

13. Is this request for Brilinta? Y N

    [If no, then skip to question 15.]

14. Does the patient have active pathological bleeding, a history of intracranial Y N

hemorrhage, or planned coronary artery bypass grafting (CABG)?

[No further questions.]

15. Is this request for prasugrel (Effient)? Y N

[If no, then no further questions.]

16. Does the patient have a history of TIA (transient ischemic attack) or stroke? Y N

Comments:

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature Date